

MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

63-026631

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON		Length of stay in 1b D O A	c. CITY OR TOWN ST Louis Co. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis County Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2528 WALLIS Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Pamela Middle Ann Last Fritz		4. DATE OF DEATH Month 6 Day 7 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-17-62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 7 Months 27 Days Hours Min.
11a. FATHER'S NAME Thomas Fritz		11b. BIRTHPLACE (City and state or country) St. Louis Mo.	
13a. MOTHER'S MAIDEN NAME Barbara Gross		12. CITIZEN OF WHAT COUNTRY USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv)		14. NAME OF HUSBAND OR WIFE Thomas Fritz Address 2528 Wallis St. (14)	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation with aspiration of gastric contents DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Fell between two connected beds -- found head-down - wedged at hips	
20c. TIME OF INJURY 1:15 P.M. 6/7/63		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) bedroom of grandmother's home		20f. CITY, TOWN, OR LOCATION University City COUNTY St. Louis STATE Missouri	
21. I attended the deceased from _____, to _____, and last saw her alive on _____. Death occurred at 12:28 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Raymond H. H. H.</i> (Degree or title) Coroner		22b. ADDRESS Clayton, Missouri	
22c. DATE SIGNED 6/11/63		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 6-10-63		23c. NAME OF CEMETERY OR CREMATORY St. Paul Churchyard	
23d. LOCATION (City, town, or county) St. Louis County		23e. STATE Mo.	
24. FUNERAL DIRECTOR Kriegshauser West Mortuary		25. DATE RECD. BY LOCAL REG. 6-8-63	
26. REGISTRAR'S SIGNATURE <i>John C. Murphy</i>			

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William D White

Licensed Embalmer No. 4241

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If the body is not embalmed, fact should be so stated above.